

Society Proceedings

NEW YORK NEUROLOGICAL SOCIETY.

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The President, DR. PEARCE BAILEY, in the Chair.

A Case of Exophthalmic Goiter, Associated with Scleroderma and Alopecia Areata.—Presented by Dr. Frederick Peterson. The patient was a single woman, 25 years old, a music teacher by occupation. She enjoyed excellent health until the age of 20, when she developed goiter. This was the first symptom noted, and subsequently the exophthalmus and tachycardia appeared. When she first came under Dr. Peterson's observation, early in November of the present year, the proptosis was marked. The pulse ranged from 90 to 120. About eighteen months ago a patch of scleroderma developed over the right hypochondriac region; this was 6x12 centimeters in dimensions. Soon afterwards a second patch appeared on the right breast, which now involved a considerable portion of the skin of that organ. Subsequently a third patch appeared under the left axillary space, a fourth in the left supraclavicular region, and a fifth in the left lower abdominal region. There were no sclerodermatous patches on the face or extremities.

About three years ago she developed a bald spot on the top of her head, about 5 centimeters in diameter. She now had three such patches of alopecia areata. There was no specific history and no hereditary taint.

Möbius states that von Leube, about 1875, was the first to record his observations of scleroderma of the face and hands in a patient with Graves' disease. Von Leube, in his book on "Medical Diagnosis," New York, 1904, says that in Graves' disease sclerema of the skin has often been observed by himself and others. Kahler, in 1888, reported a case of scleroderma with exophthalmic goiter. Jeanselme, in 1894, reported cases of scleroderma in Graves' disease. G. Singer, in 1894, stated that scleroderma frequently occurred in connection with diseases of the thyroid gland. He found that organ usually affected in ordinary scleroderma. Beer, in 1894, reported four cases of scleroderma, in all of which there was tachycardia, and the volume of the thyroid was diminished. Ditisheim, writing on Graves' disease in 1895, said that 45 per cent. of the cases observed by him in Zurich had scleroderma in addition to Graves' disease. Grunfeld, in 1896, reports a case of Graves' disease with scleroderma. Ord and Mackenzie, writing on Graves' disease in 1897, said that the association of scleroderma and Graves' disease has been recorded by several observers. Also, that alopecia has been recorded. Osler, in 1898, reports a case of a man with Graves' disease and scleroderma. Raymond, in 1898, in a lecture on scleroderma, presented two patients with scleroderma and Graves' disease. Dupré and Guillain, in 1900, reported the case of a man with Graves' disease, scleroderma and sclerodactyly. Kriger, in 1903, reports a case of a woman with sclerodactyly and Graves' disease.

As regards the relation of alopecia areata to Graves' disease, there is not so much reference to it in literature. It was mentioned in one of the cases already cited, and Dore, in 1900, writing on cutaneous affections occurring in the course of Graves' disease, refers to the frequent loss of hair, and says: "Alopecia areata is occasionally seen; Mr. Malcolm Mor-

ris has had two cases under his care." Stelwagon, in his book on "Diseases of the Skin," 1904, makes a casual reference to the association of Graves' disease with alopecia areata, in considering the pathology of alopecia. Luthlen, in his "Handbuch der Hautkrankheiten," 1904, refers to alopecia as an occasional complication with scleroderma.

We have, then, the fact that it is not infrequent to meet scleroderma in association with Graves' disease; that sometimes scleroderma is associated with alopecia and that alopecia is sometimes met with in Graves' disease. In this patient we have a combination of Graves' disease with scleroderma and also with alopecia areata.

Brain-Tumor (?) Two Cases of Doubtful Etiology.—Presented by Dr. William M. Leszynsky.

CASE I.—Sarah Z. U. S., single, 28 years old; a stenographer and typewriter by occupation. When she was first seen, in December, 1903, she complained that for six months previously she had suffered from frequent paroxysmal attacks of severe frontal and occipital cephalalgia, with vertigo, nausea and vomiting. The frontal headache was continuous and often prevented sleep. Her vision began to fail, especially in the right eye, and two months later that eye became blind. Soon afterwards the sight of the left eye was also lost. There was no history of injury to the head, alcoholism or syphilis. In childhood she had measles and diphtheria, and in her second year scarlet fever and right suppurative otitis. Menstruation began at the age of 15, and was regular during the first year. It then appeared at irregular intervals of from four to six months, and during the past year there had been amenorrhea. There was chronic constipation. The family history was unimportant. An examination of the blood showed 70 per cent. of hemoglobin; no leucocytosis. The pupils were dilated and rigid. The motility of the eyeballs was normal. There was no perception of light. Bilateral papillitis, 5 D. No retinal hemorrhages. No evidence of a kidney lesion or renal inadequacy. There was occasional right facial paresis of the lower branches of the nerve. After remaining under observation in the hospital for one week, she was discharged. Subsequently, she was trephined by Dr. Andrew McCosh at the Presbyterian Hospital. No improvement followed the operation, which failed to reveal the presence of a neoplasm. An X-ray picture of the skull was negative. There was no improvement under increasing doses of potassium iodide. The blindness persists, the disks having become atrophic.

CASE II.—Male, 28 years old, a native of Russia and a photographer by occupation, was admitted to the hospital in October, 1903. For several months he had suffered from frequent attacks of severe generalized headache, preceded or accompanied by vomiting. Soon afterwards he became blind, and complained of weakness and vertigo, with the sensation of falling to the right. His father died of diabetes; his mother was alive and well. During childhood the patient had suffered from measles and scarlatina. He was addicted to the excessive use of whiskey, beer and wine. He admitted having had gonorrhea, but denied syphilis. There was no history of injury to the head. An examination showed paralysis of the right external rectus. Both pupils were dilated and rigid, and there was no perception of light in either eye. Bilateral choked disk of 6 D., with numerous retinal hemorrhages. There was left hemiparesis, and occasional flexor rigidity in the left upper extremity. Pronounced astereognosis (fluctuating), and slight ataxia. No disturbance of tactile, pain or temperature sensibility. Both lower extremities were extended and rigid from time to time, with spurious ankle clonus and trepidation. Left knee-jerk exaggerated; both plantar reflexes exaggerated. No Babinski. Other reflexes normal. Urine, blood and X-ray examination negative. The patient was put on increasing doses of potassium iodide, and two months later all the symptoms disappeared, but the blindness persisted. The retinal hemorrhages had become absorbed and the disks were atrophic.

Dr. Graeme M. Hammond suggested that the blindness in the second case shown by Dr. Leszynsky might have been due to wood alcohol poisoning.

Dr. Leszynsky replied that in wood alcohol poisoning the condition of the eyes was one of retrobulbar neuritis and not of choked disk, and furthermore, that the blindness in the former class of cases came on very rapidly.

Dr. L. Pierce Clark said he recently saw a case quite similar to those shown by Dr. Leszynsky, and in his case the patient volunteered the statement that she had been using different sorts of bleaching hair dyes to great excess, and to these she was inclined to attribute her loss of sight. There was in this case a papillitis, followed by atrophy.

Dr. Leszynsky said that no one could make the differential diagnosis between tumor and basilar meningitis by the condition of the optic nerve or the presence of choked disk. He recently saw a case of syphilitic meningitis where the retina was filled with hemorrhages and a high degree of choked disk was present.

Tubercle of the Cerebellum.—Specimen shown by Dr. I. Abrahamson. This case was referred to the speaker by Dr. Samuel Lloyd in order to determine the advisability of an operation. The patient was a male, five years old. His family history was negative. Two years ago he had whooping cough, and about that time began to complain of pain in the head, which his father thought was due to a blow. The pain was always referred to the back of the head, and continued for about a year. Then the left side of the body suddenly became paralyzed, and this paralysis had persisted. For the past two months there had been projectile vomiting, and for the past month the child had been having three or four convulsions daily. During the convulsions, which lasted from five to fifteen minutes, the child was apparently unconscious. He cried a good deal and complained of pain, usually in the head, but also in other parts of the body when attempts were made to move him. He frequently cried out in his sleep. He had lost considerable weight, and there was a notable increase in the size of the head.

Examination showed that the patient was much emaciated. The head was retracted and flexed to the left, and all attempts at movement elicited a sharp cry of pain. The eyes were turned to the left, and upward and downward movements were impossible. The left pupil was more widely dilated than the right, and there was apparently no light nor accommodation reaction. There was no pain reaction. Attempts to look to the right were accompanied by coarse nystagmoid movements. There was marked choked disk. There was general motor weakness, and exaggeration of the triceps, wrist and knee-jerks on the left side. Plantar reflex was not obtainable. Sensibility and special senses were intact. There was no Kernig sign. The thighs and legs were flexed; the feet extended. All attempts to straighten the legs caused pain. The vomiting from which the child had suffered seemed to bear no relation to the food taken into the stomach. It occurred at any time and without warning, and seemed to cause no special distress. When the child was admitted to the hospital he was in a semi-comatose condition, which persisted up to the time of his death. He could be roused, and would answer simple questions fairly and intelligently. He had only one convulsion while in the hospital; this resembled a general spasmodic condition rather than a clonic one. The case was regarded as one of tubercular meningitis complicating general tuberculosis, and no operation was deemed justifiable.

Report of autopsy: On opening the cranial cavity the skull was found to be very thin, even for a child of six years, although the suture lines were well and firmly united. The skullcap was easily removed and the dura incised. Immediately about eight ounces of clear fluid escaped, although the brain itself had seemed to fill the entire cavity. This might

possibly be explained by the collapse of the brain, showing that the fluid had occupied the ventricles and escaped through some opening. No tubercular process was found in the meninges covering the vertex. The brain itself was removed without difficulty. On examining the basilar portion of the dura a number of miliary tubercles were found. A gross examination of the brain showed a nodule, about one and a half inches in diameter, situated in the left cerebellar lobe; it was round and fairly regular in outline, and quite firm in texture. No incision was made either into the brain or the tumor itself, the specimen being preserved intact. No tubercular process was found in the leptomeninges. Examination of the other viscera showed a general miliary tuberculosis.

A Case of Acute Dementia or Mental Stupor Following Illuminating Gas Poisoning.—Presented by Dr. Abrahamson. The patient was a woman, 55 years old, a native of Russia. Her family history was negative; the patient had always enjoyed good health, and had never had any previous mental disturbance. Six weeks ago she arose to prepare breakfast for the family on the gas range. After this she returned to bed, and later was found asphyxiated. There was no suspicion of attempted suicide. She was taken to the Gouverneur Hospital, where oxygen was given and phlebotomy done. She remained comatose for two entire days, when her intelligence slowly returned. There was no resulting paralysis or other symptoms, and she left the hospital in an apparently normal condition. Two weeks ago, however, her intelligence became affected. She would remain in one position for hours without a word or sign, apparently entirely oblivious to her surroundings, evincing no emotion whatsoever and making no complaints. There were no delusions nor hallucinations. She did not resist being moved about, and did things automatically. Her facial expression was apathetic. She did not ask for food, but when it was placed before her and she was urged very strongly she was able to feed herself. She answered one of many questions addressed to her, briefly but to the point. When once outside the house, even a few steps from the door, she lost her way. There were no lamentations, no profanity, no spells of restlessness nor excitement, no breach of ordinary decency, no undue exposure. When strongly urged, she recognized individuals, things and places.

Dr. Clark said that three cases like the one shown by Dr. Abrahamson had been seen at the Vanderbilt Clinic. In one of them in which the course and the symptoms were very similar to the one presented, a diagnosis of paramnesia following illuminating gas poisoning was made. This patient recovered entirely in the course of three or four months. The speaker said he did not think the automatism and stupid state in the case shown were sufficient grounds upon which to base the diagnosis of acute dementia.

Dr. Harlow Brooks said that in fatal cases of illuminating gas poisoning, where the patients had survived four or five days, the autopsy occasionally revealed areas of softening in the anterior lobe of the brain, and sometimes in the striate body.

Dr. Smith Ely Jelliffe said that illuminating gas contained carbon monoxide (CO), and it was known that this substance was an active hemolytic poison; hence there might be actual agglutination of blood in the blood vessels, and the production of functional disturbances, such as were presented in the case shown. These lesions also were allied to those spoken of by Dr. Brooks.

Dr. Charles L. Dana said that some years ago he reported a case of illuminating gas poisoning followed by what was described by him as double personality, which persisted for nearly a year. There was a form of memory disturbance, but the patient could talk intelligently, and was in no sense demented. He had forgotten almost everything concerning his previous life. He did not know his parents nor where he lived, but he was able to carry out a number of common, automatic things, and went

about his ordinary duties fairly well. He was also able to take care of himself. Dr. Dana said that a number of observations had been made, particularly by French writers, showing that the poison of illuminating gas had a distinct effect on the memory, and that children who were more or less constantly exposed to air contaminated by this gas were apt to have defective memories. The case shown by Dr. Abrahamson was suggestive more of memory disturbance than of true dementia.

Dr. Abrahamson, in closing said that according to the statements made by the family, his patient had improved somewhat during the past week. Clinically, the symptoms were those of dementia rather than amnesia, as the patient had never been restless or excited, nor had she had any delusions or hallucinations.

Bilateral Cervical Sympathectomy for the Relief of Epilepsy, with Report of Three Cases.—By Drs. William P. Spratling and Roswell Park.

Dr. B. Onuf thought it worth while to examine the excised portion of the sympathetic nerve in all cases where a sympathectomy was done, although if any pathological changes were found in it, it might be difficult to say whether they were primary or secondary.

Dr. Clark said that the first case reported by Dr. Spratling had been under his care for a time. This patient was the first in line of birth of six children; he was a "blue baby," the labor having been instrumental and extremely difficult. The inflammatory changes found in that case might have been due to trauma, and the speaker thought there was some doubt whether the case was really one of true epilepsy.

Dr. Pearce Bailey thought it was rather remarkable that so little attention had hitherto been given to the cervical sympathetic in connection with these cases. Its importance was shown by the result of the pathological findings in the cases reported by Dr. Spratling.

Dr. Spratling, in closing, said that while there was some doubt in the beginning as to whether the case referred to by Dr. Clark was one of true epilepsy, the patient subsequently developed typical grand mal attacks. The speaker said he was still a little skeptical in regard to the use of the knife in general in the treatment of epilepsy, and he was rather doubtful whether the improvement in the cases he had reported would be lasting. He had always inclined to the view that epilepsy was a condition usually beyond the aid of the knife, although in many instances even a simple surgical operation, no matter what, seemed to prove at least temporarily beneficial, perhaps by its effect on the general metabolism. This, if nothing else, might render certain operations justifiable in some cases.

Traumatic Epilepsy in Its Medico-Legal Relations.—By Dr. Arthur Conklin Brush.

Dr. Edward D. Fisher said that Dr. Brush's large personal experience with this class of cases rendered his views on the subject of value. The speaker thought the fact was fairly well established, both by clinical observation and animal experimentation, that direct injury to the brain could cause epilepsy even in the absence of any hereditary predisposition.

Dr. Spratling said he entirely agreed with Dr. Fisher. While the occurrence of true epilepsy as the result of a trauma, and independent of any hereditary taint or auto-intoxication, was rare, such cases had come under his observation.